

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Wilhemina Boulter					2a. DATE OF DEATH MONTH DAY YEAR June 22, 1979			2b. HOUR 10 ⁰⁸ P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 22 1885		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centreville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. #2, Box 399	
14. FATHER'S NAME FIRST MIDDLE LAST Henry NMN Mercer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Heinefield						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Hospital Records		ADDRESS Chestertown, MD 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 486- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 21</u> , 19 <u>79</u> , to <u>June 22</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>K. K. Wun M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kin-Kue Wun, M. D.				22e. ADDRESS Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/26/1979		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN STATE Rock Hall, Md.			
24. FUNERAL DIRECTOR NAME <u>William Wells</u>				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE <u>Peter H. O'Quinn</u>	

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1 5 1 2 1 4 1

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 1 2 2

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VICTORIA C BUTLER			2a. DATE OF DEATH MONTH DAY YEAR JUNE 24, 1979			2b. HOUR M 11			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JUNE 3, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD.			
10. CITY OR TOWN OF DEATH Chester Town		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENT-QUEEN ANNES HOS.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b. KIND OF BUSINESS OR INDUSTRY VARIOUS	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY KENT		13c. CITY OR TOWN WORTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.F.D.	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES A WALLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-14-186		17. INFORMANT ADDRESS MR S. S. GADON, A.B. HALLAN & 1394 WAINWRIGHT ST. W. I.M. 4270 DE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } disen (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diabetic									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 30, 1970 to Dec 14, 1978 , that (I) (we) last saw the deceased alive on Dec 1, 1978 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. Gottfried Baumann				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann				22e. ADDRESS Chester Town, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-23-79		23c. NAME OF CEMETERY OR CREMATORY UNION CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WORTON KENT MD			
24. FUNERAL DIRECTOR NAME Zemuth Walley				ADDRESS Chester Town, Md.		25a. DATE REC'D. BY REGISTRAR JUL 24 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undertaker, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12121

CLARK COUNTY

(14)

RECEIVED

EX-100-100

12121

12121

Items 21c. & 22a. FOR STATE REGISTRAR Film #G533 7-5-79 as 79 15123 REG. NO.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) Dorothy Gloria Chester			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 3 19 79			2b. HOUR M 5:30 P.M.		
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1939	6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 6 15 19 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD		
10. CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) White Marsh Beach-off Rt 445				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N. Chestertown		12b. KIND OF BUSINESS OR INDUSTRY Hospital
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Queen Anne's 13c. CITY OR TOWN Stevensville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Bay City, Stevensville Md.			13f. ZIP CODE 21666
14. FATHER'S NAME FIRST MIDDLE LAST Elmer McCellan Clark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ozella Weaver			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		
16a. SOCIAL SECURITY NO. 217-34-9865			17. INFORMANT Box 982 Old Love Point Victoria Lindler Rd. Stevensville Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 984- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR 4:59 P.M. 6/3/ 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) precipitated from bridge. jumped from bridge			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bridge to water		21f. LOCATION (CITY OR TOWN, STREET) (Center Span Section) E/BoundWmPrestonLaneBridge, COUNTY STATE MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Virginia L Dolan			M.D. Assistant			DATE SIGNED 6/16/79		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street, Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 18, 1979		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Stevensville Queen Anne Md.	
24. FUNERAL DIRECTOR Helfenbein-Hubbard Funeral Home			ADDRESS Chester, Md.			25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE L. H. Brady

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 15124			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR A M			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Clement Craddock Sr.				June 1, 1979 8:16 A M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 20, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lino-Type Operator		12b. KIND OF BUSINESS OR INDUSTRY Printing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Galena		13e. STREET ADDRESS P.O. Box 118	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Benjamin Craddock				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances NMN Gates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWI 163-07-2471		17. INFORMANT ADDRESS Hospital Records - Chestertown, Maryland 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diverticulitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastricplasty</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Remorhage + chronic duodenal disease</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION May 10 - 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Seabro		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 9, 1979, to June 1, 1979, that (I) (we) lost the deceased alive on June 1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE Robert W. Farr, M.D.				DEGREE		22c. DATE SIGNED 6/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.				22e. ADDRESS Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/7/79		23c. NAME OF CEMETERY OR CREMATORY Forrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middletown N.C. & Del.	
24. FUNERAL DIRECTOR NAME Howard E. Fellows, Millington, Md. 21651				25a. DATE REC'D BY REGISTRAR JUN 4 1979		25b. REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR		7 9 1 5 1 2 5		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M			
John				William		Hodges		Crouch		6-22-79		12:30 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN					
Male		White		May 14, 1905		74 YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.				Kent County MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent and Queen Anne's Hospital										Owner		Marina	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
				Maryland		Kent		Rock Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rte. #1 Box 166			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. ADDRESS							
John James Grouch				Mary ? Hodges				21620							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT									
No				-		220-32-0075		Hospital Records - Chestertown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>410-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>C Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 22, 1979</u> to <u>June 22, 1979</u> , that (I) (we) lost saw the deceased alive on <u>June 22, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Patrick A. Molony</u> DEGREE										22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony, M.D.										22e. ADDRESS Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL				6-26-79		WESLEY CHAPEL CEM.				ROCK HALL KENT MD					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HELFENBEIN-HUBBARD FUNERAL				RT#1 Box 67 HOME CHESTER				JUN 27 1979		<u>Patrick A. Molony</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR 10:30				
LON		W.	GILLENWATER		June 8, 1979						
3. SEX male		4. RACE white		5. DATE OF BIRTH Oct. 3, 1905		6. AGE (In years lost birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Saltville, VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent		Md.			
10. CITY OR TOWN OF DEATH Betterton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Sun Oil Machinist		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Betterton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME Floyd Gillenwater		First	Middle	Lost	15. MOTHER'S MAIDEN NAME Susan White		First	Middle	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or years of dates of service) Yes Navy WW2		16b. SOCIAL SECURITY NO. 163 07 1530		17. INFORMANT wife Mrs. Catherine Gillenwater		Address Betterton Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-22</u> , 19 <u>68</u> , to <u>6-8</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-14</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert W. Farr</i>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/8/79			
22d. PHYSICIAN'S NAME (Type) Robert W. Farr				22e. ADDRESS Chestertown, Md. 21620							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 11, 1979		23c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.		23d. LOCATION (City or Town) Still Pond, Md.		(County)		(State)	
24. FUNERAL DIRECTOR <i>St. Will's Wells</i>				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JUN 12 1979		25b. REGISTRAR'S SIGNATURE <i>Robert W. Farr</i>			

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DEPARTMENT OF COMMERCE
BUREAU OF COMMERCE
WASHINGTON, D. C.

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UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF COMMERCE
WASHINGTON, D. C.

OFFICE OF THE SECRETARY
WASHINGTON, D. C.

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TO THE SECRETARY
WASHINGTON, D. C.

FROM THE
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
7 9 1 5 1 2 7									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Miller David Goodman					2a. DATE OF DEATH MONTH DAY YEAR June 16, 1979			2b. HOUR 12:10 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 25, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2 Box 162	
14. FATHER'S NAME FIRST MIDDLE LAST William Wilton Goodman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anna Pearce				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Army -WW1		17. INFORMANT Hospital Records Chestertown, Maryland		ADDRESS 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>COPD</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Tumor of Lung - prob. Ca</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 14, 1979</u> to <u>June 16, 1979</u> , that (I) (we) lost saw the deceased alive on <u>June 16, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. Gottfried Baumann, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/18/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann, M.D.					22e. ADDRESS Chestertown, Maryland 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 18, 1979		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall Kent Co. Md.			
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home Chester, Md.						25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

1 2 1 2 1



Private

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 5 1 2 8			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Lillie Viola Hadaway				2a. DATE OF DEATH MONTH DAY YEAR June 20. 1979		2b. HOUR 11:52P	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 28, 1880		6. AGE (IN YEARS LAST BIRTHDAY) 99	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall	
14. FATHER'S NAME FIRST MIDDLE LAST James Alfred Walbert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Copper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-74-2859		17. INFORMANT ADDRESS Hospital Records, Chestertown, Maryland	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - CARDIAC ARREST 4029 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) hypertension & CVA PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 20, 1979 to June 20, 1979 , that (I) (we) lost saw the deceased alive on June 20, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patrick A. Molony M.D. 22b. PHYSICIAN'S NAME (TYPE OR PRINT) 22c. DATE SIGNED						22c. DATE SIGNED	
22d. ADDRESS Chestertown, Maryland						22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-24-79		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Kent Co. Md.	
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home, Chester, Md.				25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE Patrick A. Molony	

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "University" and "Chicago" are faintly visible.]

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		7 9 1 5 1 2 9																	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR									
						Johnson		June 12, 1979		6:12 P.M.									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
Female		Negro		June 12, 1979		0 YRS.				28									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		U.S.A.				Kent County MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)																	
Chestertown		Kent and Queen Anne's Hospital																	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)												12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Queen Anne's		Centreville				318 South Commerce Street											
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
John Lawrence Johnson				Anna May Pritchett															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
NO				Newborn				Hospital Records, Chestertown, Maryland 21620											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) <u>interuterine anoxia</u>																			
7605 DUE TO, OR AS A CONSEQUENCE OF (b) <u>abruptio placenta</u>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>trauma (accidental fall of mother)</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>June 12</u> , 19 <u>79</u> , to <u>June 12</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 12</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE DEGREE								22c. DATE SIGNED											
								6/13/79											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS											
John L. Morgan, M.D.								Chestertown, Maryland 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Disposal		6-18-79		Hospital Incinerator		Chestertown		Kent		Md.									
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Kent & Queen Anne Hospital-Chestertown, Md.						JUN 25 1979													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) WILBERT LEWIS QUILLEN			2a. DATE OF DEATH June 15 1979			2b. HOUR 9:50 P														
3. SEX male			4. RACE white			5. DATE OF BIRTH July 2, 1898			6. AGE (In years last birthday) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Kent											
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civilian State Worker			12b. KIND OF BUSINESS OR INDUSTRY (Ret.)											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RFD Fairlee								
14. FATHER'S NAME Reverdy Quillen			15. MOTHER'S MAIDEN NAME Berdie Morris																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212 38 0661			17. INFORMANT Carol Quillen 103 Kent St. Chestertown, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Chronic lung disease															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 2 hr years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 5-12 , 1979, to 6-15 , 1979, that (I) (we) last saw the deceased alive on 6-15 , 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE Harry Paul Ross															DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6/16/1979		
22d. PHYSICIAN NAME (Type) Harry Paul Ross			M.D.			22e. ADDRESS Chestertown, Md. 21620														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/18/79			23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery			23d. LOCATION (City or Town) (County) (State) Centreville, Md.											
24. FUNERAL DIRECTOR W. Wells			ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR DATE JUN 21 1979			25b. REGISTRAR'S SIGNATURE Harry Paul Ross											

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OFFICE OF THE DIRECTOR OF THE BUREAU OF THE CENSUS
WASHINGTON, D. C.

UNITED STATES GOVERNMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR			7 9 1 5 1 3 1 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) John Shepard Raynor Jr.			2a. DATE OF DEATH MONTH DAY YEAR June 23, 1979			2b. HOUR 12:31 A_M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 28, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent And Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) METAL LATHER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Haven Road	
14. FATHER'S NAME FIRST MIDDLE LAST John Shepard Raynor Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene NMN Hartman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 187-05-8958		17. INFORMANT ADDRESS Hospital Records Chestertown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction - 410 - DUE TO, OR AS A CONSEQUENCE OF Cardiac Arrest - (ASCVD) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF ASCVD (c) ASCVD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from June 1, 1979 to June 23, 1979 , that (I) (we) lost saw the deceased alive on June 23, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Patrick A. Molony, M.D.			DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony, M.D.			22e. ADDRESS Chestertown, Maryland 21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-27-79		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE near Chestertown Kent Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Helgenbein-Hubbard Fun. Home Chester, Md. 21619					25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE Patrick A. Molony			

1 5 1 2 1 2 4

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15132

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HENRY CLAY SMITH			2a. DATE OF DEATH MONTH DAY YEAR June 17, 1979			2b. HOUR 1030AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 1, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent				
10. CITY OR TOWN OF DEATH Millington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE Md.			13b. COUNTY Kent		13c. CITY OR TOWN Millington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21651	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida L. Lamdin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 220-26-2238		17. INFORMANT ADDRESS Elizabeth B. Smith, Millington, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 2859 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac insufficiency</u> (c) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks -</u> <u>2 years</u>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 9</u> 19 <u>54</u> to <u>June 17</u> 19 <u>79</u> that (I) (we) lost saw the deceased alive on <u>June 17</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Geza Koralewski</u> DEGREE <u>MD</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Geza Koralewski, M.D.					22c. DATE SIGNED <u>6-17-79</u> 22c. ADDRESS Millington, Md. 21651					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/20/79		23c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Millington Kent Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Howard E. Fellows, Millington, Md. 21651					25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

2 2 1 2 1 2 2 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 1 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie May Tolson			2a. DATE OF DEATH MONTH DAY YEAR June 26, 1979			2b. HOUR 10:55 A M				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 8, 1880		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.				
12. CITY OR TOWN OF DEATH Chestertown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		15. KIND OF BUSINESS OR INDUSTRY home		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. CITY Queen Anne		16c. CITY OR TOWN Chestertown		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS P.O. Box 472	
17. FATHER'S NAME FIRST MIDDLE LAST Galeb ? Davis			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca ? Robinson							
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			20. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-46-3123			21. INFORMANT ADDRESS Hospital records - Chestertown, Md.				
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic congestive failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>① Bronchitis ② Diabetes mellitus</u>										
23. DATE OF OPERATION			24. CONDITION FOR WHICH OPERATION WAS PERFORMED			25. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			32. LOCATION STREET CITY OR TOWN COUNTY STATE				
33. I certify that (I) <u>the hospital</u> attended the deceased from <u>June 24, 1979</u> to <u>June 26, 1979</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>June 26, 1979</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.										
34. SIGNATURE <u>Harry P. Ross</u> MD DEGREE						35. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		36. DATE SIGNED <u>6-29-79</u>		
37. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Harry P. Ross, M.D.						38. ADDRESS Chestertown, Md. 21620				
39. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			40. DATE <u>6-29-79</u>		41. NAME OF CEMETERY OR CREMATORY STEVENSVILLE CEM.		42. LOCATION CITY OR TOWN COUNTY STATE STEVENSVILLE Q.A. MD			
43. FUNERAL DIRECTOR NAME HELFFENBEIN - HUBBARD			44. ADDRESS CHESTER MD		45. DATE RECEIVED BY REGISTRAR JUL 3 1979		46. REGISTRAR'S SIGNATURE <u>Harry P. Ross</u>			

BP

22121 41

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(1/9 A15 ME (5))
15M/7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15134

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EUGENE BOONE SPENCER WESSEL		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6/24/79 DEAD <input type="checkbox"/> 6/24/1979		2b. HOUR 3:30 P
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 4/20/1927	6. AGE (IN YEARS) (LAST BIRTHDAY) 52 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6/24/1979
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.	
10. CITY OR TOWN OF DEATH nr. Chestertown	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route # 20	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Acme Stores	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RFD Pomona
14. FATHER'S NAME FIRST MIDDLE LAST Spencer Wessel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Bland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218 20 6583		17. INFORMANT ADDRESS Mirian Wessel Chestertown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Driver of car involved in head on collision				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:30 P.M. 6-24 1979	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Route 20	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3 miles from Chestertown Kent Maryland		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Robert W. Farr		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		DATE SIGNED 6/24/79
EXAMINER'S NAME (TYPE OR PRINT) Chestertown Kent Co. Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/28/1979	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown Md. 21620	
24. FUNERAL DIRECTOR NAME Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 28 1979

Robert W. Farr
Wells

43121 121 21

1910

Wm. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 5 1 3 5 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M	
Clara Frances Wheeler								June 21, 1979		4:15 P	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		May 4, 1918		61					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Kent County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent and Queen Anne's Hospital						Production Line		Food	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Kent		Chestertown				P.O. Box 105			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Melvin James Crew				Anna Mae Lloyd							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		21620			
No		220-09-5604		Hospital Records,		Chestertown,		Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <i>Pneumonia - Electrolyte imbalance</i>											
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of lung</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>with metastases</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from June 6, 1979, to June 21, 1979, that (I) (we) lost saw the deceased alive on June 21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE OF PHYSICIAN										22c. DATE SIGNED	
Patrick A. Molony, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		6-23-79		CRUMPTON CEMETERY		D.A. Co. MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HELFENBEIN-HUBBARD		CHESTER MD.		JUN 27 1979		Patrick A. Molony					

1 2 1 3 2

14

CHICAGO, ILL. 1900
JANUARY 10, 1900
TO THE CHIEF OF POLICE
CITY OF CHICAGO
FROM THE CHIEF OF POLICE
CITY OF CHICAGO
RE: [illegible]

[illegible handwritten notes and text]

6.2
[illegible handwritten notes and text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 1 3 6

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME FIRST MIDDLE LAST William Bernard Willson			June 19 1979			8:10 P.M.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 16 16		
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			10. CITIZEN OF WHAT COUNTRY? U.S.A.			11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
12. CITY OR TOWN OF DEATH Chestertown			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent And Queen Anne's Hospital			14. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland			15b. COUNTY Kent			15c. CITY OR TOWN Rock Hall		
16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			17. STREET ADDRESS P.O. Box# 119					
18. FATHER'S NAME FIRST MIDDLE LAST Leonard Augustine Willson DEC.			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Elizabeth Boyer DEC.					
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			21. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) Army WWII 220-03-7959			22. INFORMANT ADDRESS Hospital Records Chestertown, Maryland		
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (d) 410- ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS					
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			32. LOCATION STREET CITY OR TOWN COUNTY STATE		
33. I certify that (I) (this hospital) attended the deceased from June 18, 19 79, to June 19, 19 79, that (I) (we) lost saw the deceased alive on June 19, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			34. SIGNATURE Harry P. Ross, M.D.			35. DATE SIGNED 6-20-79		
36. PHYSICIAN'S NAME (TYPE OR PRINT) Harry P. Ross, M.D.			37. ADDRESS Chestertown, Maryland 21620					
38. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			39. DATE 6-22-79			40. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem. Rock Hall Kent Co. Md.		
41. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home, Chester Md.			42. ADDRESS			43. DATE RECEIVED BY REGISTRAR JUN 27 1979		

7. 4. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 8

Excluded

21-55-3

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 7 9 1 5 1 3 7
REG. NO. | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
Norris Eugene Wilson | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 26, 1979 | | | 2b. HOUR
M | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
March 31, 1891 | | 6 AGE (IN YEARS LAST BIRTHDAY)
88 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Kent MD. | | | |
| 10 CITY OR TOWN OF DEATH
Worton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
At Home | | | | 12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Labor | | 12b. KIND OF BUSINESS OR INDUSTRY
Various | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Kent | | 13c. CITY OR TOWN
Worton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
R.F.D.# | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Wilson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Susie White | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO
214-28-8079 | | 17. INFORMANT ADDRESS
Mrs. Mary Brooks Worton, R.F.D.#, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
4292
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN STATE
5/2/79 | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Apr. 19 19 79 , to May 26 19 79 , that (1) (we) last saw the deceased alive on May 26 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles P. Adamo M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5-29-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles P. Adamo M.D. | | | | 22e. ADDRESS
Chestertown, Maryland 21620 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 30, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Union United Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
R.F.D. Worton Kent Md. | | | |
| 24. FUNERAL DIRECTOR
Thomas W. Kelly | | | | ADDRESS
Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 19 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy | |

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Dorra Ross Young | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
June 5, 1979 | | 2b. HOUR P M
10:15 P | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
March 10, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Arkansas | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Kent County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Chestertown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kent and Queen Anne's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Dental Assist. | | 12b. KIND OF BUSINESS OR INDUSTRY
Denistry | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
W.Va. | | 13b. COUNTY
Morgan | | 13c. CITY OR TOWN
Berkeley Springs | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Route 3 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Morgan Ross | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Victoria Elliot | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
421-26-8667 | | 17. INFORMANT ADDRESS
Hospital Records 21620 Chestertown, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COPD
DUE TO, OR AS A CONSEQUENCE OF (c) CHF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumonia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 28 , 19 79 , to June 5 , 19 79 , that (I) (we) last saw the deceased alive on June 5 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
K. K. Wun, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
June 5, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kin K. Wun, M.D. | | | | 22e. ADDRESS
Chestertown, Maryland 21620 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/7/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakland Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Morgan Co., W.Va. | | | |
| 24. FUNERAL DIRECTOR NAME
W.W. Helsley, Berkeley Springs, W.Va. | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
JUN 12 1979 | | 25b. REGISTRAR'S SIGNATURE
Hickory McCreedy | |

BP

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Directorate of Health and Social Services, Ministry of Health

Mr. J. H. [Name], [Address], [City]

Dear Sir,

I am writing to inform you that the [Subject] has been [Action]

Yours faithfully,

[Signature]

[Name], [Title]

[Address]

[City]

[Postcode]

[Phone Number]

[Fax Number]

[Email Address]

[Website]

[Footer]